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In the Supreme Court of the United States

October Term, 1984

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,
PETITIONERS

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.,
RESPONDENTS

BRIEF IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI TO THE U.S. COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTION PRESENTED

Did the Court of Appeals correctly conclude that 42 U.S.C. § 1395ff and 42 U.S.C. § 405(h) did not deprive Respondents of a federal judicial forum for redress of their substantial statutory and constitutional claims.

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STATUTORY PROVISIONS AND REGULATIONS INVOLVED

28 U.S.C. §§ 1331 and 1361; 42 U.S.C. §§ 405(g), 405(h), 1395a, 1395ff, 1395u(b)(3), 1395u(b)(3)(C); and 42 C.F.R. 405.504(b). These authorities are reproduced either in the body of this Brief or in the Appendix to the Petition previously filed in this matter.

STATEMENT

1. Background

The substantive merits of this case involve a challenge to a regulation promulgated by the Secretary of Health and Human Services (Secretary) which permitted differential treatment being accorded to certain allopathic (M.D.) family physicians (and their patients) versus all other allopathic physicians (and their patients) under the Medicare Program. The differential treatment alleged by Respondents and found by both the trial court and court of appeals was implemented through the creation and maintenance of separate fee screens which placed allopathic family physicians in the same fee screen as podiatrists, chiropractors and dentists while allopathic physicians of different specialities were placed in another separate specialty fee screen.

Petitioners mischaracterize the present case from the first sentence of the Statement of their Petition. The question presented in this case is not whether the court of appeals erred in finding that 42 U.S.C. § 405(h) and 42 U.S.C. § 1395ff did not preclude federal court jurisdiction for a Medicare "amount of benefit" case. Rather the question is whether the lower court was correct in concluding that these statutory provisions cannot be interpreted to erect such a jurisdictional bar as to preclude Respondents from any forum — administrative or judicial — for the redress of their statutory and constitutional claims.

2. The Medicare Act

Petitioners' general description of the Medicare Program is sufficient and will not be repeated here in detail, except for those provisions that relate directly to the present case or those provisions not discussed by Petitioners.

Under the general scheme of the Medicare Program, the Secretary is authorized to enter into contracts with private insurance companies in order to administer Part B of the Medicare Program. 42 U.S.C. (& Supp. V) 1395u. Part B of

the Medicare Program concerns services provided by physicians. In contrast, Part A of the Medicare Program, 42 U.S.C. (& Supp. V) 1395c, et seq.), provides coverage for the reasonable cost of hospital and other institutional care. The distinction between Parts A and B of Medicare are germane to the present appeal only to the extent that it serves as a point of contrast for both past precedents and the review mechanisms permitted under each Part.

Under Part A, determinations of both "entitlement to benefits" and "amount of benefits" are made by the Secretary. 42 U.S.C. § 1395ff(a)[1] Under Part B only the determination of "entitlement to benefits" is made by the Secretary. ibid. Under Part A, an individual dissatisfied with either an eligiblity or amount of benefits determination is entitled to a hearing by the Secretary and to judicial review of the Secretary's final decision pursuant to 42 U.S.C. 405(g). See 42 U.S.C. § 1395ff(b)[2] Under Part B, and pur-

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[1] This statute states as follows:

The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

[2] This statute states as follows:

(1) Any individual dissatisfied with any determination under subsection (a) of this section as to —

(A) whether he meets the conditions of section 426 or section 426a of this title, or
(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title, or subsection 1819, or
(C) the amount of benefits under part A (including a determination where such amount is determined to be zero) shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

suant to § 1395ff(b), only an individual dissatisfied with entitlement determinations is afforded a hearing by the Secretary and judicial review of the Secretary's final decision.

The hearing rights of individuals dissatisfied with an "amount of benefits" determination under Part B of the Act are treated separately pursuant to another provision of the Medicare Act. Specificially, § 1395u(b)(3)(C) provides that an individual will be granted an opportunity for a "fair hearing by the carrier" in cases of controversy over $100.00 with regard to services furnished or not acted upon with reasonable promptness.[3]

The other relevant statutory provision, 42 U.S.C. § 405(h), is a general statutory provision applicable to the Medicare Act by reference through 42 U.S.C. § 1395ii, which makes § 405(h) applicable to the Medicare Act to the same extent it is applicable to Title II of the Social Security Act. Section 405(h) generally indicates that the findings of the Secretary, following a hearing, are binding and no further review (judicial or otherwise) is permissible unless otherwise provided. Under the general provisions of the Social Security Act, a hearing by the Secretary (and judicial review thereafter) is accorded by 42 U.S.C. § 405(g). However, 42 U.S.C. § 1395ii fails to make § 405(g) applicable to the Medicare Act.

In addition to defining the type of hearing (conducted by the Secretary or conducted by the carrier) and discussing

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[3] This statute states as follows:

> (3) Each such contract shall provide that the carrier —
>
> * * *
>
> (C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

appellate remedies, there are other regulatory and administrative provisions which concern themselves with the fair hearing procedure that must be utilized by a carrier in cases where a request for payment is denied or when the amount of such payment is in controversy. The fair hearing conducted by the carrier is defined by regulations promulgated by the Secretary and certain provisions of the "Carrier's Manual."[4] The types of challenges that may be heard by the carrier are carefully delineated by regulation. 42 C.F.R. 405.801. The regulations provide for a hearing when a party is dissatisfied with a determination denying a request for payment, the amount of payment or where the request for payment is not being acted upon with reasonable promptness. A party is then given a right to a "fair hearing" (42 C.F.R. 405.820) conducted by a hearing officer designated by the carrier. (42 C.F.R. 405.823). The jurisdiction of the hearing officer is carefully circumscribed by regulation as follows:

> The hearing officer in exercising the authority to conduct a hearing on this Section 1842(b)(3)(c) of the Act is to comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as with policy statements, instructions and other guides issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the carrier. 42 C.F.R. 405.860.

The restrictions opposed upon the hearing officer's jurisdiction are made even more explicit by the Carrier's Manual, the compilation of guidelines a hearing officer is required by the above regulation to follow. Section 12016 of the Manual states:

> Authority — the HO occupies a significant position in the administrative appeals process affording dissatisfied

[4] The Carrier's Manual was compiled by the Health Care Financing Administration. Its declared purpose is to serve as "practical operating instructions needed by the contractors responsible for the administration of the supplementary and medical insurance program — Part B Medicare. (forward to Carrier's Manual).

individuals with hearing rights as provided in Section 1842(b)(3)(C) of the Act. Authority of the HO is limited to the extent that he must comply with all provisions of Title XVIII of the Act and regulations issued thereunder, as well as with HCFA rulings, general instructions, and other guides issued by HCFA with the Medicare Bureau. *The HO does not have the prerogative of overruling the provisions of the law or of interpreting them in a way different than that of the Medicare Bureau when he is in disagreement with their intent; nor may he use hearing decisions as a vehicle for commenting upon the legality, constitutional or otherwise, of any provision of the Act or regulations relevant to the Medicare Program.* (Emphasis added)

3. Proceedings

Respondents commenced this action on the 8th day of October, 1976. Respondents alleged the differential treatment of family physicians, compared to all other types of physicians in the State of Michigan, violated substantive due process requirements of the Fifth Amendment to the United States Constitution and the Medicare Act, specifically 42 U.S.C. 1395a (which guarantees a free choice of physicians by patients under the Medicare Program) and 42 U.S.C. § 1395u(b)(3) which requires that prevailing fee limitations be based upon "similar services"). No monetary relief was requested, but Respondents did request a finding that the maintenance of separate fee screens by Petitioners in administering the Medicare Program violated the Medicare statute and the Fifth Amendment. Respondents requested that the court enjoin Petitioners from treating family physicians differently from other physicians for purposes of the Medicare Program.

Respondents' statutory claim based upon 42 U.S.C. § 1395u(b)(3)[5] asserted that, contrary to the Medicare Act's

[5] 42 U.S.C. § 1395u(b)(3) states as follows:

"In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary

(Footnote continued on next page.)

mandate that "similar service" be the basis for determining reasonable charge, the Secretary had promulgated a regulation which authorized the carrier to segregate and group physicians on the basis of specialty practice for the purpose of developing reimbursement screens used for all types of procedures, including primary care procedures, thereby according different payment for similar service. See 42 C.F.R. 405.504(b).[6]

Prior to commencing suit, and in October, 1974, Respondents requested a hearing with the Carrier to provide the individual Respondents with an opportunity to demonstrate that Respondent-physician's training and experience were such as to warrant equal payment for primary care procedures. In December, 1974, the Carrier responded to the request indicating that Respondents could utilize a peer review procedure. In March, 1975, the Carrier further clarified the scope of the hearing by indicating that an adjudication as to the reasonableness of the specialty diffe-

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(Footnote continued from previous page.)

charges for similar services generally made by the physician or other person furnishing such service, as well as the prevailing charge in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or request for payment made under this Part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) a prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover seventy-five (75%) percent of the customary charges made for similar services in the same locality during the last preceding calendar year . . ."

[6] This regulation provides:

"The range of prevailing charges in a locality may be different for physicians or other persons who engage in a specialty practice or service than for others. Existing differentials and the level of charges between different kinds of practice or service could, in some localities, lead to development of more than one range of prevailing charges for application by the carrier in its determination of reasonable charges. Carrier decisions in this respect shall be responsive to the existing patterns of charges by physicians and other persons who render covered services and should establish differentials in the level of charges between different kinds of practice or service only where in accord with such patterns."

rential could *not* be involved and the Carrier would accept no adjudication which eliminated such a differential. Additionally, Respondent-patient, without counsel, protested the prevailing fee determination as to services performed by her treating physician and was notified by the Carrier that she was without recourse and nothing could be done.

Prior to trial, the Secretary moved to dismiss Respondents' Complaint for lack of jurisdiction as to the statutory and regulatory claim and as to the constitutional claim on the basis that the constitutional claim was insubstantial. In December, 1977, the Secretary's motion was denied by the district court in a memorandum opinion which noted:

> I am influenced by the improbability that Congress would intentionally authorize an administrative agency to delegate to a private contractor the power to violate the Constitution of the United States in the name of the United States without recourse.

Following trial on the merits and with regard to the differential screens permitted by 42 C.F.R. 405.504(b), the district court held that the Carrier had neither developed a procedure to determine what types of professional services were similar nor carried out a statistical study to determine actual charging patterns for different types of providers. Instead, the carrier had established three "screens" in order to make reasonable charge calculations. The Carrier implemented this differential screen procedure in such a fashion as to group certain Respondent-family practice physicians in the same pool as dental surgeons, chiropractors and podiatrists. The district court found the regulation authorizing such a classification scheme (42 C.F.R. 405.504(b)) to be plainly inconsistent with the clear mandate of the Medicare Act which "mandates the customary charges of physicians for similar services to be the test for reimbursement." 502 F. Supp. at 755.

The district court furthermore found that this classification scheme violated yet another provision of the Medicare

Act, 42 U.S.C. § 1395a, because it tended to influence a beneficiary's choice of physician and reduced that beneficiary's reimbursement solely by virtue of the choice of the type of physician to perform a particular medical service.[7]

Since the district court found the Secretary's and Carrier's actions to be a clear violation of the Medicare Act, it did not consider the constitutional arguments advanced by Respondent yet it did state that "such segregation is not rationally related to a legitimate purpose of the Medicare statute." 502 F. Supp. at 575.

It is important to note that in stating the case as developed before the district court, the Petitioner again mischaracterizes the proceedings. In footnote 1 of its Petition filed in this matter, the Petitioner indicates that the Secretary acknowledged an error before the district court in that board-eligible family physicians were classified as "non-specialists." Specifically, it was conceded before the district court that board-eligible family physicians should not have been placed in the same screen as chiropractors and podiatrists. However, Petitioners misstate the record wherein they state that the Secretary agreed that board eligible physicians would thereafter not be classified in this fashion. In fact, while conceding the error, the Petitioner declined the district court's suggestion that a voluntary remedy by way of reclassification take place. (See Appendix A)

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[7] The district court demonstrated the financial impact of this classification scheme by focusing on the effect upon respondent-patient. Respondent-patient was a Medicare recipient whose treating physician was a family physician who had been at practice for twenty-three (23) years. While being on staff at three different hospitals and while being an instructor at Michigan State University, this physician was neither board eligible nor board certified by the American Board of Family Practice. The district court noted that solely as a result of selecting this physician (a choice protected pursuant to 42 U.S.C. § 1395a) respondent-patient was in fact paying more for her physician visits and treatments although paying the same premium as another recipient who may have chosen a physician defined by the Petitioner as a "specialist."

By way of remedy, the district court issued a mandatory injunction directing the Petitioners to provide a single screen for all physicians separate and apart from a screen for chiropractors, podiatrists and dentists.

The court of appeals affirmed the decision of the district court, both in terms of subject matter jurisdiction and the substantive merits of the lawsuit. However, that court determined that the remedy adopted by the district court went too far. The court of appeals remanded the case to the Secretary for reconsideration of the reimbursement plan with the proper focus of "similar service."

As to jurisdiction, the court of appeals recognized that this Court's decision in *U.S.* v *Erika*, 456 U.S. 201 (1982), held that Congress clearly and convincingly intended no judicial review of amount of benefit cases. Contrary to the impression gained from a reading of the Petition in this matter, the court of appeals did not first determine this to be an amount of benefits case and nonetheless find jurisdiction.[8] Rather, after a review of the applicable statutes and case law, the court concluded that jurisdiction did exist under the particular circumstances of this case since there would be no other forum for Respondents to press their statutory and constitutional claims and there was no "clear and convincing" showing of legislative intend to bar such jurisdiction.

As to the merits of Respondent's case, the court of appeals found that the "touchstone" of 42 U.S.C. § 1395u(b)(3) is "similar service" and that there was an obvious inconsistency between this statute and the disputed regulation. The court of appeals found the regulation "irra-

[8] In the Petitioners' zeal to convince this Court that the circuit court's opinion was erroneous, the Petitioners again mischaracterize the record. Petitioners quote at page 6 of their Petition the circuit court as stating "the eventual result of [this] suit may cause an increase in the amount of reimbursement." The actual quote from the court of appeals is that, "while the eventual result of this suit may cause an increase in the amount of reimbursement, *that does not necessarily follow*." (Emphasis added)

tional" and "invalid" 728 F. 2d at 329. Because the regulation was statutorily unsound the court did not address the constitutional issues raised by the case. See *Hagans* v *Levine*, 415 U.S. 534 (1974).

It is pertinent to appreciate that the Petition raises only the issue of subject matter jurisdiction. Both the district court and court of appeals found in favor of the Respondents on the substantive merits of this case and found, in short, that the Secretary had promulgated a regulation (42 C.F.R. 405.504(b)) which was inconsistent with the Medicare Act. Since Petitioners have failed to perfect an appeal on the substantive merits of the lawsuit, this aspect of the case is not properly before this Court and need not be decided. *Namet* v *U.S.*, 373 U.S. 179 (1963); *Ryan* v *U.S.*, 379 U.S. 61 (1964); *F.D. Rich Company, Inc.* v *U.S.*, 417 U.S. 116 (1974); *U.S.* v *ITT Continental Baking Company*, 420 U.S. 223 (1975). By failing to perfect an appeal on the substantive merits of this case, the Petitioners have failed to contest the fact that a violation of the law took place.[9] Accordingly, the Petition in this matter postures the case such that this Court is to decide whether there was jurisdiction to find the statutory violations in fact found by the district court and upheld by the court of appeals.

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[9] In a footnote Petitioners attempt to take issue with the substantive merits of this case as well. See Petition, fn. 5. However, Petitioners are obviously bound by the fact that they have chosen to appeal this case only on jurisdictional grounds. Additionally, the comments made by Petitioners are in complete contravention of the testimonial record established in this case. Simply stated, the record established that there was no meaningful difference between physicians of different specialties performing the *same* procedure.

SUMMARY OF ARGUMENT

This case presents the issue of whether an administrative branch of the government charged with enforcing a complex federal program (the Medicare Act) can first develop a system of hearings and review that differentiates and classifies types of claims and affords those claims differential hearing and appellate avenues and then contend that substantial statutory and Constitutional claims (for which no administrative review is offered) can be foreclosed from judicial review. The import of this Court's decisions in *Weinberger* v *Salfi*, 422 U.S. 749 (1975); *United States* v *Erika, Inc.*, 456 U.S. 201 (1982); *Heckler* v *Ringer*, ____ U.S. ____; 104 S. Ct. 2013 (1984); and *Schweiker* v *McClure*, 456 U.S. 188 (1982) strongly indicate that the interpretation placed upon 42 U.S.C. § 405(h) and § 1395ff by the Petitioner in untenable since it would foreclose the substantial statutory and constitutional claims presented by the Respondents.

In this case, Respondents requested an administrative review but were informed that such a review could not address the very claims which Respondents wished to pursue. The regulatory and administrative authority pertinent to this matter, in fact, stripped the administrative process of the ability to resolve the claims pressed by Respondents. The decisions of this Court have never concluded that § 405(h) or § 1395ff preclude jurisdiction over substantial statutory or constitutional claims for which no other review is accorded. Rather, this Court has in fact addressed substantial constitutional claims arising out of the Medicare Program. See *Schweiker* v *McClure, supra*. This Court's decisions in *Salfi, Erika,* and *Ringer* stand for the propositions that claimants must first pursue any available administrative remedy before asserting federal court jurisdiction and that federal court jurisdiction is precluded for "amount of benefits" cases. The present case is not properly characterized as an amount of benefit case since Respondents, as in *McClure,* made a broad statutory and constitutional claim against a federal regulation. The claims made did not ad-

dress the specific amount to be paid but rather addressed a classification scheme inconsistent with a mandate of the Medicare Act. These claims were certainly not insubstantial as the district court found a statutory violation and that court's decision was affirmed by the court of appeals. The Petition challenges the lower court only on the issue of subject matter jurisdiction.

The construction of §§ 405(h) and 1395ff advanced by Petitioners would allow Petitioners to violate the law with impunity. Indeed, in the district court Petitioners admitted a violation of the law, refused the district court's suggestion that a remedy be fashioned, but yet now insist that no forum exists for the redress of the very violation they concede. It is respectfully suggested that this Court must interpret 42 U.S.C. §§ 405(h) and 1395ff in such a fashion as to avoid such a serious constitutional issue and in a fashion which also gives meaning and effect to the various provisions of the Act.

ARGUMENT

Through the last several years, this Court has had several occasions to consider the administrative review mechanisms of the Social Security Act and the related issue of federal court jurisdiction. See *Weinberger* v *Salfi*, 422 U.S. 749 (1975); *United States* v *Erika Inc.*, 456 U.S. 201 (1982); *Heckler* v *Ringer*, _____ U.S. _____; 104 S. Ct. 2013 (1984). In addition, this Court has previously addressed, without any significant discussion of jurisdiction, a constitutional challenge to the administrative review mechanisms of Part B of the Medicare Program. *Schweiker* v *McClure*, 456 U.S. 188 (1982). The Petition filed in this matter incorrectly posits that the decision of the court of appeals in this matter is inconsistent with the collective import of these decisions and calls for the grant of a writ of certiorari. Contrary to the Petition's suggestion, a review of these decisions indicates that this Court has never interpreted or applied 42 U.S.C. § 405(h), or other provisions of the Social Security Act, as foreclosing all forums to redress substantial statutory or constitutional challenges to the Act.

In *Weinberger* v *Salfi*, *supra*, this Court faced a constitutional challenge to provisions of the Social Security Act which prohibited a wage earner's widow or stepchild from receiving insurance benefits unless the relationship to the wage earner existed nine months prior to his death. This Court carefully reviewed each of the three sentences contained within § 405(h) and first concluded that this section constitutes more than a requirement for exhaustion of administrative remedies. This Court secondly rejected any narrow reading of the language "any claim arising under . . . the Social Security Act" since the facts of *Salfi* involved Social Security benefits and provided "both the standing and substantive basis for the presentation of . . . constitutional contentions." 422 U.S. at 761.

A third element of this Court's opinion in *Weinberger* v *Salfi*, *supra*, was its distinction of the prior case of *Johnson* v *Robison*, 415 U.S. 361 (1974). This Court distinguished

§ 405(h) from a statute applicable in that case (38 U.S.C. § 211(a)) by stating that acceptance of the government's interpretation of the statute in *Robison* would have meant that no judicial consideration of a constitutional challenge could have taken place. This Court stated:

> Not only would such a restriction have been extraordinary, such that 'clear and convincing' evidence would be required before we could ascribe such intent to Congress, . . . but it would have raised a serious constitutional question of the validity of the statute so construed. 422 U.S. at 763 (citations omitted)

The court noted that the satutory scheme faced in *Salfi* was distinct from *Robison* since there was no foreclosure of important constitutional challenges. Rather, those challenges could be first channeled through the administrative process pursuant to the terms of 42 U.S.C. § 405(g) and then pursued in federal district court. This Court noted:

> In the present case, as will be discussed below, the Social Security Act itself provides jurisdiction for constitutional challenges to its provisions. Thus, the plain words of the third sentence of Section 405(h) do not preclude constitutional challenges. They simply require that they be brought under jurisdictional grants contained in the Act, and thus in conformity with the same standards which are applicable to non-constitutional claims arising under the Act . . . 422 U.S. at 762

It is clear from reviewing the decision in *Salfi* that this Court was concerned that § 405(h) not be interpreted to preclude constitutional challenges. This principle was neither ignored nor forgotten in the subsequent decisions of this Court.

In *United States* v *Erika, supra,* this Court faced a case involving Part B of the Medicare Act. The judicial action in that case was commenced following an administrative review by the carrier pursuant to 42 U.S.C. § 1395u(b)(3)(C). The substantive challenge boiled down to the carrier's de-

termination to base "reasonable charge" upon a price list utilized by the Respondent-provider. There was no constitutional claim pressed before this Court. See *U.S.* v *Erika, supra,* at fn. 5.

This Court's opinion in *Erika* dealt mainly with the correct interpretation to be given to § 405(h) in conjunction with § 1395ff. Because § 1395ff failed to provide for a hearing by the Secretary (or judicial review thereafter) for "amount of benefits" cases under Part B, and because the legislative history revealed an intent to distinguish between "amount of benefits" cases under Part B and other types of challenges for purposes of judicial review, this Court determined that the administrative hearing afforded in *Erika* was appropriate and no further judicial review was permissible.

Contemporaneously with issuing the *Erika* opinion, this Court also handed down its opinion in *Schweiker* v *McClure, supra.* The *McClure* case once again dealt with Part B of the Medicare Program but was distinct from *Erika* in that the challenge in that case was directed at the hearing procedure mandated by 42 U.S.C. § 1395u(b)(3)(C) and implemented through regulation. Once again, the claimants in *McClure* had gone through an administrative hearing and, thereafter, filed suit in district court contending that the hearing which they were afforded was constitutionally infirm. Relevant to this discussion, this Court did not consider the basic jurisdictional issue but went on to substantively address the constitutional claims and ruled that the carrier hearing, as mandated by the statute and implemented through regulations, passed constitutional muster. *McClure* was notably distinct from *Erika* since the issues brought before the federal district court were not "amount of benefits" issues but were rather broad constitutional challenges to the overall administrative review process adopted by the Secretary (through promulgation of several regulations) and acted upon by the carrier.

Just recently this Court issued its opinion in *Heckler* v *Ringer, supra,* which again focused upon judicial review of

a Medicare case, although this Court's decision was limited, in the main, to a discussion of judicial review of a Part A claim. *Heckler* v *Ringer, supra* at fn. 4. In *Ringer,* Respondents initially challenged an instruction and ruling by the Secretary which had the purpose of limiting Medicare reimbursement for a particular surgical procedure. This Court distinguished between the Respondents since three of the Respondents had had the surgery performed prior to the Secretary's limiting instructions whereas the fourth Respondent (Ringer) had yet to undergo the surgery claiming that he could not afford to do so if it was not a covered benefit. Before the administrative review available under Part A had been completed, a challenge was made to the Secretary's limiting instruction through filing suit in federal district court. The precise issue faced by this Court was whether the Respondent could pursue their case in federal district court prior to having their claims first channeled into the administrative process available under Part A and, in the case of Respondent Ringer, before the surgery was actually performed.

This Court held that § 405(h) barred federal court jurisdiction over the Respondents' claims since Respondents had failed to exhaust their administrative remedies provided under § 405(g) in the confines of their Part A claims. As to Respondent Ringer, this Court declined the invitation not to enforce the provisions of § 405(h) to a Medicare claimant who had yet to undertake the surgery since to do otherwise would have opened the door and allowed a by-pass of the administrative remedy provided by the Act. This Court noted:

> If we allow claimants in Ringer's position to challenge in federal court the Secretary's determination . . . that BCBR surgery is not a covered service, we would be inviting them to by-pass the exhaustion requirements of the Medicare Act by simply bringing delcaratory judgment actions in federal court before they undergo the medical procedure in question. 104 S. Ct. at 2025.

From these precedents, the Petitioners weave their argument for requesting relief from this Court. From the *Salfi* opinion they take the principle that § 405(h) applies to any action "arising under" the Medicare Act. From the *Erika* opinion they take the principle that all "amount of benefit" cases are without recourse to judicial review. From the *Ringer* opinion they take the principle that the administrative channels and judicial review established by § 405(g) and §405(h) cannot be circumvented by a premature district court action by clothing benefits cases in procedural dress. Petitioners then characterize the present case as an "amount of benefits" case which "arises under" the Medicare Act and is hence without federal court jurisdiction pursuant to § 405(h). Despite the Petitioners' best efforts, however, the precedent of these cases cannot collectively establish the principle that judicial review is foreclosed in a Part B Medicare case in which a statutory and constitutional challenge is made and for which there is no administrative process to address these challenges. Indeed, the decisions of this Court stand for quite the opposite.

An important element of this Court's analysis in the *Salfi* case was the recognition that the challenges made by the claimants could be properly addressed and channeled through the administrative process provided by § 405(g). In *Erika* judicial review was foreclosed but only over certain types of challenges, namely amount of benefits cases, since there was clear legislative intent to free the judicial process of these small benefit cases. This Court recognized that the constitutional claims presented were neither pressed before this Court nor of a substantial nature. *Erika* was consistent with Salfi regarding foreclosure of statutory or constitutional claims since the claims raised in *Erika* were concerned solely with the determination of amount of benefit and expressly did not concern substantial statutory or constitutional claims. A judicial forum was not available since such a forum was not expressly provided by statute *and* legislative history revealed a clear intent to bar judicial review of the very type of claim being pressed. In *Ringer*

the claimants had recourse to administrative review (and judicial review thereafter) under § 1395ff(b) and § 405(g) but simply failed to pursue it.

Perhaps the best indication that this Court's opinions do not foreclose statutory or constitutional claims under the Medicare Act is this Court's opinion in *McClure*. Decided the same day as *Erika*, this Court readily considered the constitutional challenges presented without being concerned with the initial jurisdictional question.

The present case was initiated as a statutory and constitutional challenge to a regulation promulgated by the Secretary. Respondents were not seeking any specific payment level concerning a particular medical service or procedure (contrast both *Erika* and *Ringer*) but were claiming that the Secretary and Carrier had gone beyond the basic mandate of both the Medicare Act and the United States Constitution. Like *McClure*, Respondents made a broad challenge to the promulgation of a regulation. That challenge was not based upon a question of medical necessity or proper *application* of the Medicare regulations to a particular claim for payment. Such claims could have been pursued through the administrative hearing mechanism mandated by 42 U.S.C. § 1395u(b)(3)(C) and established by regulation.

Unlike the claimants in *Erika* or *Ringer*, Respondents did not seek payment of a necessarily higher amount or payment for a procedure determined to be unnecessary or otherwise nonreimbursable by the Secretary. Respondents' claims were based upon the premise that whatever payment was to be made should be made according to "similar service" and the regulation in issue violated this statutory premise. Respondents objected not to the application of the classification scheme permitted by the regulation but the classification scheme itself. Such a determination is not concerned with "amount of benefits" as discussed and defined in *Erika*.

Respondents' statutory and constitutional claims had to be pursued in the statutory and regulatory matrix that had been established for the Medicare Program. The Medicare Act, pursuant to § 1395ff(b) does not discuss either administrative review or judicial review of such challenges under Part B. Similarly, while 42 U.S.C. § 1395u(b)(3)(C) calls for a hearing by the carrier, the Secretary specifically removed from the carrier's power the capacity to address the very type of challenge being pursued by Respondents. It will be recalled that the applicable regulation states:

> The hearing officer exercising the authority to conduct a hearing on this § 1842(b)(3)(C) of the Act is to comply with all of the provisions of Title XVIII of the Act and the regulations issued thereunder, as well as with policy statements, instructions, and other guides issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the carrier. 42 C.F.R. 405.860.

In addition, the hearing officer assigned by the carrier is specifically instructed by the Secretary not to decide or comment upon the legality or constitutionality of any regulation relevant to the Medicare Program. As stated previously, the Carrier's Manual specifically states:

> The HO does not have the prerogative of overruling the provisions of the law or of interpreting them in a way different than that of the Medicare Bureau when he is in disagreement with their intent; nor may he use hearing decisions as a vehicle for commenting upon the legality, constitutional or otherwise, of any provision of the Act or regulations relevant to the Medicare Program. Carrier's Manual, § 12016.

Although faced with this foreclosure of the very claims they wish to press, Respondents, nonetheless, requested an administrative hearing making very clear the type of claim being pursued. As previously mentioned, Respondents' inquiries were answered in such a fashion to make abundantly

clear that the carrier hearing afforded by § 1395u(b)(3)(C) simply did not have the ability to remedy the specific injustice claimed by Respondents. Respondents belief that it is ironic that the regulatory scheme fashioned by the Petitioner and the Petitioner's specific statements to Respondents demonstrated the fact that the administrative review available could not have addressed the Respondents' challenges, yet Petitioner now attempts to pigeonhole Respondents' challenges as "amount of benefits" claims — which of course could have been administratively addressed.

There is yet another more practical reason why characterization of the present case as an amount of benefits case is inaccurate. Respondent-Academy is a state chapter of a national organization known as the American Academy of Family Physicians. This organization consists of approximately 1,500 licensed allopathic physicans who have agreed to meet the standards of the national organization. The American Board of Family Practice was established in 1969 as a specialty practice board. Because certification as a family physician specialist has existed basically from the inception of the differential screens in dispute in this matter, there were board certified family physicians who were placed in the specialty screen. Therefore, the relief sought by Respondents stood to potentially decrease the amount of reimbursement of certain family physician members who had been previously placed in the specialty screen utilized by the Carrier in this case. Accordingly, it is inaccurate to characterize the Respondents' case as simply seeking to increase the "amount of benefits" they may receive under the Medicare Program. Respondents' claims were clearly delineated to address the classification scheme and differential treatment being accorded and the illegal and unconstitutional aspects of the disputed regulation.

It is a matter of long precedent with this Court that the foreclosure of all forums to address substantial constitutional claims itself raises "serious constitutional questions." See *Johnson* v *Robison, supra,* see *Bob Jones University* v

Simon, 416 U.S. 725 (1974). This Court has called it a "cardinal principle" that statutory provisions are to be interpreted so as to avoid this very sort of basic constitutional question. See *United States* v *Thirty-Seven Photographs*, 402 U.S. 363 (1971); *Johnson* v *Robison, supra; Crowell* v *Benson*, 285 U.S. 22 (1932).

This precedent certainly has not been ignored by this Court in addressing the proper interpretation of § 405(h). Indeed, this Court in *Salfi* recognized this precedent and reviewed the other provisions of the Social Security Act and concluded that " . . . the plain words of the third sentence of § 405(h) do not preclude constitutional challenges." 422 U.S. at 762. Likewise, under the facts present before this Court in *Ringer*, the "procedural" claims being pressed by the claimants could still have been pursued if only those claimants would have first made use of the administrative remedy available to them pursuant to § 1395ff(b) and § 405(g). Respondents are not suggesting that the interpretation of § 405(h) shift from the previous decisions of this Court. The simple fact is this provision has never been interpreted by this Court as foreclosing all forums for the redress of substantial statutory and constitutional challenges to the Act. To do so in this case would raise a constitutional question of the first dimension. Justice Brandeis recognized this principle many years ago with the following words:

> When dealing with constitutional rights . . . there must be the opportunity of presenting in an appropriate proceeding at some time, to some court, every question of law raised, whatever the nature of the right invoked or the status of him who claims it. *St. Joseph Stockyard Co.* v *U.S.* 298 U.S. 38 (1935) (Brandeis, J., concurring)

In interpreting and applying § 405(h) in the context of medicare cases, federal courts have universally declined to interpret § 405(h) so as to preclude all forums for the address of substantial constitutional questions. See *Hospital San Jorge, Inc.* v *United States*, 598 F. 2d 684 (1st Cir.

1979); *Dr. John T. McDonald Foundation, Inc.* v *Califano*, 571 F. 2d 328 (5th Cir. 1978), cert. denied 439 U.S. 893 (1978); *Trinity Memorial Hospital of Cudahy, Inc.* v *Associated Hospital Service, Inc.*, 570 F. 2d 660 (7th Cir. 1977); *South Windsor Convalescent Home, Inc.* v *Matthews*, 541 F. 2d 910 (2nd Cir. 1976); *St. Louis University* v *Blue Cross Hospital Service*, 537 F. 2d 283 (8th Cir. 1976), cert. denied sub nom. *Faith Hospital Association* v *Blue Cross Hospital Service, Inc.*, 429 U.S. 977 (1976); *Chelsea Community Hospital, SNF* v *Michigan Blue Cross Association*, 630 F. 2d 1131 (6th Cir. 1980); *United States* v *Aquavella*, 615 F. 2d 12 (2nd Cir. 1979); *Starnes* v *Schweiker*, 715 F. 2d 134 (4th Cir. 1983), vacated and remanded sub nom. *Heckler* v *Ringer, supra; National Association of Home Health Agencies* v *Schweiker*, 690 F. 2d 932 (D.C. Cir. 1982) cert. denied, 103 S. Ct. 1193 (1983). It would certainly be inappropriate to claim that there is a "conflict" among the inferior federal courts on this issue as a basis for granting a writ of certiorari. See Supreme Court Rule 17.1(a).

To conclude that § 405(h) may serve to foreclose substantial statutory and constitutional claims becomes that much more untenable when the entire statutory and regulatory scheme is considered. Even in cases where no key constitutional claim is made, this Court has held that judicial review of an agency's final determination will not be foreclosed unless there is "clear and convincing evidence" of a legislative intent to so limit or restrict a judicial forum. *Abbott Laboratories* v *Gardner*, 387 U.S. 136 (1967). A recent opinion of this Court suggests that this presumption of judicial review can, under certain circumstances, be overcome where the intent to preclude judicial review is "fairly discernible in the statutory scheme." *Block* v *Community Nutrition Institute*, ____ U.S. ____ ; 104 S. Ct. 2450 (1984). See also, *Data Processing Services* v *Camp*, 397 U.S. 150 (1970).

A review of the statutory and regulatory scheme here certainly does not reveal a fairly discernible intent to pre-

clude judicial review for a Medicare Part B case which raises substantial statutory and constitutional issues. As previously discussed, the impact of a § 1395ff in conjunction with § 1395u(b)(3)(C) and § 405(h) evidences a legislative intent to channel small amount of benefit cases through an administrative hearing process conducted not by the Secretary but by the carrier.

Pursuant to regulatory and administrative authority, the carrier hearing process, as required by § 1395u(b)(3)(C), is specifically limited and cannot address a statutory or constitutional challenge. What is discernible in this scheme is only the foreclosure of judicial review of those issues for which a meaningful administrative hearing is available. The legislative history discussed in *Erika* obviously cannot be read as evidencing an intent to foreclose judicial review for claims of a type other than the amount of benefit claims discussed in that history.

A basic tennet running through the cases which have discussed § 405(h) is that claimants should make use of any administrative avenues of relief before instituting suit in the federal courts. See *Weinberger* v *Salfi, supra;* and *Heckler* v *Ringer, supra*. However, where there is no meaningful administrative review (as in this case where the unavailability of that administrative review is apparent both from the applicable regulatory and administrative authority and through response to a specific request for hearing) an intent to foreclose all judicial review is certainly not discernible from the statutory scheme.

Petitioner, citing this Court's order of remand in *Heckler* v *Starnes*, ____ U.S. ____; 104 S. Ct. 2673 (1984) asks this Court to similarly remand the current case to the Sixth Circuit Court of Appeals for reconsideration in light of this Court's Opinion in *Ringer*. A review of the facts of the court of appeals' *Starnes* opinion indicates that there was a great similarity to the facts present in the *Ringer* opinion. However, further review indicates that a remand would not be appropriate in the case at bar.

In *Starnes*, the court of appeals was faced with a case in which both Medicare beneficiaries and providers of care challenged certain determinations made by the Secretary which served to limit the amount of reimbursement received for the rendering of a particular procedure — computerized tomography. The Secretary had established a national ceiling for payment of this procedure through the issuance of several letters and memoranda. Like *Ringer*, the claimants alleged that the actions of the Secretary were "procedurally" incorrect and made a constitutional challenge as well. Before reaching this Court, court of appeals dismissed the constitutional claim terming said claim "frivolous." See *Starnes* v *Schweiker, supra* at fn. 4.

The court of appeals' decision in *Starnes* is inconsistent with this Court's opinion in *Ringer* since both cases involved claimants seeking reimbursement for a particular procedure which the Secretary, through an allegedly inappropriate procedural means, had limited or denied. In *Ringer*, this Court took specific note that the bottom line of the claimant's challenge was payment for a particular medical service. The same characterization has merit with regard to the *Starnes* case.

It would be erroneous to conclude that the case at bar present a similar issue as that faced by *Ringer* and *Starnes*. This is not a case which labels an amount of benefits determination as a procedural error or anything of the type. As previously discussed, Respondents' dispute was with a classification scheme, not application of a regulation or particular decision on a claim for payment. The Court of Appeals for Sixth Circuit recognized this distinction as can be demonstrated through another Medicare Part B case previously decided by that Court.

In *Herzog* v *Secretary*, 682 F. 2d 121 (6th Cir., 1982) the Court of Appeals for the Sixth Circuit faced a case in which the claimants disputed the fact that chelation therapy was held by the Secretary to be non-reimbursable. The claimants sought and were afforded an administrative review of

this adverse decision. They consequently filed suit in the federal district court but made no constitutional challenge to the adverse determination until an adverse district court opinion led to court of appeals' review. The court of appeals, relying extensively on this Court's opinion in *Erika*, ruled that federal court jurisdiction did not exist to hear the claimants amount of benefits case. The court of appeals specifically noted that the Plaintiffs had failed to allege any constitutional claim in their complaint.

Under these circumstances it is clear that the Court of Appeals for Sixth Circuit is mindful of this Court's *Erika* opinion and that the case at bar is decidedly distinct from the facts presented in the *Ringer* and *Starnes* cases. Accordingly, it would be inappropriate to remand this matter back to the court of appeals for further consideration in light of this Court's *Ringer* opinion.

CONCLUSION

The Petition for Writ of Certiorari should be denied. If this Court decides to grant the Petition, it is respectfully submitted, for the reasons previously discussed, that a remand to the Court of Appeals for the Sixth Circuit is inappropriate and that this Court simply docket this matter for decision on the merits.

Respectfully submitted,
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APPENDIX

(63)

TRIAL TRANSCRIPT

* * * trial.

Q. Have you ever heard of any rationale with then HHS as to why the carrier in Michigan has treated board eligible family physicians different from other types of board eligible physicians?

A. I have never seen anything that fully explains that. I have been under the impression at one time or another that there were differences in the various board rules dealing with the requirements of becoming board certified that the carrier was concerned about, but I do not recall what they are specifically.

MS. MAYES: Your Honor, if I might just raise a question. We have indicated at the beginning of this case that we believe that we were incorrect in defining family practioners, that is, those who were board eligible, as not being specialists, and that therefore we conceded that fact before this trial ever began. That was an incorrect application of that board eligible definition, so that board eligible family practioners should be defined as specialists by the carrier in the State of Michigan.

THE COURT: And should be put in the screen?

MS. MAYES: That question is what is left open, but the definition of what we called them was (64) incorrect.

THE COURT: All right. Go ahead.

BY MR. GILCHRIST:

Q. Would it be a fair statement that the rationale that you have heard for treating board eligible family physicians differently from other board eligible physicians has never been related to any charging patterns?

A. I am not sure I understand your question. I am sorry.

Q. Well, you said you talked about—there was something about qualifications of speciality boards as one of the rationale.

A. It had been my understanding that there was a difference in requirements for board certification, for remaining board eligible rather for physicians in family practice as opposed to physicians in other speciality fields. Now that may or may not be so. I don't know. I have no personal knowledge of that.

Q. Okay, but at the time you understood that to be the rationale. Did you treat that as the basis on which to put the board eligible FP into a separate screen?

A. Well, that determines on what the charge pattern really is.

Q. That is what I am trying to figure out. Did you ever hear the rationale that there was a difference in charge patterns between a board eligible family physician * * *